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DENTISTRY AND REGIONAL MEDICAL PROGRAMS

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Dentistry's role in new national health legislation: Regional Medical Programs

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By the expansion of hospital dental services, the establishment of treatment centers for maxillofacial rehabilitation, emphasis on programs for continuing dental education, and other projects, dentistry can become an important part of the Regional Medical Programs that provide better care for more patients.

Reproduced here because of its relevance to Regional Medical Programs -- and especially because of one of the Amendments to P.L. 89-239 relative to dentists -- is a paper entitled "Dentistry's Role in New National Health Legislation: Regional Medical Programs" given by Rudolph H. Friedrich, DDS, Director of the Division of Oral Surgery of the Department of Dental and Oral Surgery of Columbia University. Dr. Friedrich presented this paper to the 19th National Dental Health Conference sponsored by the Councils on Dental Health and Dental Care Programs of the American Dental Association in Chicago April 8 - 10, 1968. It was subsequently published in the Journal of the American Dental Association in October, 1968.

A review of the development of the National Institutes of Health, which began in 1939 with the National Cancer Institute, and the appropriations that have been made to them indicates that dentistry consistently has been far behind the rest of the institutes in time and financial support for the development of its research activities. The great strides made since 1956 to bring dental research to its present position, where research in the dental schools is one of the outstanding aspects of dental education, must be attributed directly to the legislative and research development program of the American Dental Association.

In 1960, Congress authorized the establishment of the second program, namely, the Center Grant Program, through which the Institutes of Health could improve the quality of health care for the population. Briefly, the purpose of this program was to establish in appropriate institutions the capability for translating basic research into ap-

plied research, that is, to convert the discoveries growing out of basic research programs into better treatment of disease or its prevention. Dentistry has made considerable progress, and in 1966, the University of Washington and the University of Pennsylvania received grants to establish centers for applied dental research. In 1967, grants were approved for the Universities of North Carolina, Michigan, and Alabama.

In 1965, Congress amended public law 89-239 to establish what is most commonly known as the Regional Medical Programs. This third element of the health programs of the National Institutes of Health is designed to improve the care available to the general public by taking the developments of the center grant programs to the health professionals and all health agencies in direct contact with the general public. In the words of Russell Nelson at Johns Hopkins University: "We have great resources of cake medicine in this country but a dearth of bread medical care."

Concomitant with the development of Regional Medical Programs has been the establishment of two other federal programs that include extensive programs for the provision of health care. The general provisions of the Office of Economic Opportunity (OEO) legislation authorize the establishment of Neighborhood Health Centers that must include dental care in their operation. Under Title II of public law 89-97, which also requires the development of the state Medicaid programs under its Title XIX, the Children's Bureau was authorized to develop programs for children and youth. In these programs for the provision of comprehensive health care for children from birth to age 18, the inclusion of dental care is mandated. The programs also include medical care, mental health, health education, and social service.

Under the direction of the OEO, Neighborhood Health Centers are being established as satellites of teaching hospitals. Under the direction of the Children's Bureau, children and youth programs are being established in voluntary and city hospitals.

In all of these developments, dentistry's active participation is mandated or definitely permitted. There is no need to wait while the ADA wages a long campaign to open the way for dentistry to make its impact in Regional Medical Programs, OEO programs, or Title II Children's Bureau programs. The responsibility for being involved in these programs rests with the community, the district, and the state dental professions. Of course, there is much that the ADA can and will do to provide guidance. The National Dental Health Conferences are examples of such support.

The language of public law 89-239 permits and even urges indirectly that dentistry be included in the policy structure of the Regional Medical Programs, although it does not mandate such inclusion. Dental schools and dental societies should have no difficulty in obtaining representation on the advisory committees of Regional Medical Programs or the establishment of a subcommittee on dentistry. If they understand the concept of Regional Medical Programs and are prepared to recommend, develop, and see to the proper establishment and operation of programs that will improve the health care of patients with heart disease, cancer, stroke, or such related diseases as diabetes, renal disease, and pulmonary disease, their participation and contribution will be welcome.

Since the beginning of the planning for Regional Medical Programs, there has been little formal inclusion of dentists in the programs and little project development by dental agencies. Part of this delay arises from the desire to make the Regional Medical Programs reflect the particular characteristics and requirements of the regions with a minimum of direction and definition from the federal level. In addition, in the initial year of the program, there was some confusion regarding what the programs could do, how they could do it, and who would be involved where.

The establishment of the categories of heart disease, cancer, stroke, and related diseases as the immediate targets of the program tended to center attention on the disease entities themselves rather than on the patient who had the disease. It was difficult for the medical people, health agency people, and dentists themselves to relate dentistry's efforts in any significant measure to the acute processes of these diseases. The First National Conference on Regional Medical Programs reflected this confusion. To the dentists who attended the conference it seemed that the primary objective of the conference was to stimulate the medical schools and medical centers through the medical deans to develop programs that would increase the knowledge and skills of the health professionals and hospitals in the community, that is, to open the doors of these centers of advanced knowledge and skills and take the benefits out into the communities for the health professionals and agencies that provide the

actual health care to the general public. The contribution of the dental profession did not receive any significant attention at that conference.

The Second National Conference on Regional Medical Programs was devoted to the description of the experiences of the Regional Medical Program headquarters during the developmental phase. The development of operating programs, operational projects, and programs for which concepts were being converted to project protocols were described in a large number of short papers.

One came away from the second conference with the conviction that:

- Dentistry could be an integral component of Regional Medical Programs if it were involved in the policy structure on the advisory committee and if a dental subcommittee were established. This information evolved from many personal discussions with individual directors of Regional Programs.
- Dentistry must consider the essential lifetime dental care for patients who have been treated for heart disease, cancer, stroke, or related diseases, and even more important, consider the potential role for dentistry in the early recognition of signs and symptoms and through this, the prevention of heart disease, cancer, stroke, and related diseases. The patients, in fact, require considerable dental rehabilitation and maintenance as patients on a total health basis for the rest of their lives.

The patient with heart disease has been a problem in the dental office throughout history. The management of pain, dental disease, and infection in these patients has been so difficult that until recent improvements in the medical management of the patient with heart disease, any but absolutely essential dental care was avoided as constituting an impossible burden for the patient. At present, the young dentist, trained on a total patient-total health concept, is accustomed to relating the treatment to the medical characteristics of the patient. For the patient with heart disease, we still need to develop the most effective system for assuring the availability of adequate dental care at the most propitious time and place during his recovery and rehabilitation.

The patient with cancer has been of particular concern to the dental profession during the past 20 years since the profession and the American Cancer Society instituted continuing education for the early recognition of cancer. The best cure statistics for oral malignancy are directly attributable to these continuing education programs. The rapid developments in head and neck surgery in the management of head, neck, and oral cancer has increased the number of oral deformities resulting from the removal of malignant lesions more rapidly than the dental profession has been able to provide well-trained maxillofacial prosthodontists or develop sufficient maxillofacial prosthetic rehabilitation centers for training and rehabilitative treatment. Radiation of the salivary glands during radiation therapy for malignant lesions of the face, mouth, and jaws causes a loss of the caries-immunity factor in saliva and in too many instances a complete melting away of the remaining natural teeth and the subsequent problems of osteoradionecrosis, dental infection, massive loss of tissue, and speech defects.

Until recent years, the patient with a stroke, isolated from society as a major problem in nursing care, seldom became a serious problem for the dental profession except for the removal of teeth that were causing acute symptoms. With the rapid advances made in the stabilization and rehabilitation of this patient, the dental problems are clear and unavoidable. The acute stages of his cerebrovascular episode and the long recovery periods in nursing homes must be recognized as periods when maximum preventive dental services must be provided. The patient should receive at least oral hygiene preventive services during the period of medical rehabilitation to avoid the unnecessary loss of the remaining natural teeth and the subsequent construction of complete upper and lower dentures as an additional burden to an already formidable program of motor and speech rehabilitation.

Dental students and the practicing dentist must be trained to evaluate the soft and hard tissues of the mouth and at least observe gross abnormalities in a patient's physical functions. The dentist can and should be qualified to refer patients to the physician for an overdue physical examination. The early symptoms of diabetes in the mouth and the relationship of diabetes to difficulty in bringing periodontal disease under control has been well established in dentistry. The early symptoms of congestive heart failure, subacute bacterial endocarditis, and coronary distress can often be elicited or disclosed during a history taken by the dentist who is trained in the fundamentals of physical diagnosis as an integral function of his patient-evaluation program.

Because of the need for the relief of pain, the prevention of dental disease, and the periodic re-

call systems that are effective in most dental offices, patients come to the dental office much more regularly than they seek the services of a physician. Still, the influence of the dentist in health education and his stimulation of periodic health examination has been virtually untapped.

What, then, are some of the programs or projects that dental agencies, institutions, or individual dentists should consider for their communities with the support of Regional Medical Programs?

Promotion and expansion of hospital dental services

The modern hospital has evolved through constantly changing functions and objectives from a warehouse for the illnesses that were an abomination to society to the place where it at present has the responsibility of centralizing the expensive hardware of health care, administering the efficient production and distribution of comprehensive health care, coordinating a complex myriad of professional skills, and conducting a broad scope of health education and extensive programs in clinical research and community public health.

The expansion of hospital dental services is being stimulated by such governmental programs as the OEO and the Children's Bureau. The Veterans Administration is expanding the role of its hospitals in undergraduate, advanced, and continuing dental education. To quote from Doctor Coggeshall, in what has become known as the Coggeshall report prepared under the auspices of the American Association of Medical Colleges:

"Continued expansion of government activity in the health field can be anticipated. Institutions and organizations concerned with health care as well as with health education—including both instruction and research—will need to act responsibly and effectively to make the fullest use of government assistance and to avoid the government becoming dominant as a consequence of their own default or the default of others."

For dentistry, then, the opportunity exists to guide, promote, and utilize the expansion of hospital dental service. Their potential in basic dental education, advanced dental education, and continuing education—all of which are essential to the improvement of the dental care available to the patient with heart disease, cancer, or stroke—is one of the bright spots in dentistry's future. The expansion of the hospital dental service through federal support of the OEO, Children's Bureau, Medicaid, or Regional Medical Programs is the responsibility of the dental schools, dental societies, specialty societies, hospital dental staffs, or individual dentists who have the imagination to use the forces of federal, state, and local governmental health programs. They can guide the local health agencies and hospitals in the establishment of effective hospital dental services and develop the utilization of such services to the mutual advantage of public and private patients, the dental community, and the hospital.

Dental education

Undergraduate and advanced dental education must consider the expansion of clinical training in the hospital environment. The key to this development is the formal affiliation of dental schools with the dental services of teaching hospitals and the assumption of joint responsibilities by the schools and the hospitals for the operation of clinical clerkship programs for undergraduate dental students as well as internship and residency training programs in the various specialty areas of dental practice. Although this is a deeper extension into the educational process than is generally considered in Regional Medical Programs, the hospital training for undergraduate and advanced trainees in medicine has a long established history. The future dentist must receive more of his training in the hospital environment if he is to properly contribute to the new delivery systems of health care which in the future will be centered almost entirely in the hospital. There can be no question about the value of clinical clerkships in stimulating the dental student voluntarily to seek productive and challenging, mixed or limited dental internships and subsequent resident training. The early exposure of the undergraduate student to the hospital environment has demonstrated its value in orienting him to interprofessional contact as well as total health-total patient concepts.

The availability of expanded hospital dental services as training facilities for undergraduate and advanced dental education will alter the economics of dental education in the future. The understanding of the medical status of patients will be increased when a dentist is trained in a

hospital instead of the sterile outpatient atmosphere, with the well-screened patients, of the dental school.

Continuing dental education

A discussion of continuing education programs under Regional Medical Programs must differentiate between the requirements for physicians and dentists. For a long time, 50% to 55% of the physicians have had continuing education through their hospital affiliations and the requirements for attendance at hospital activities such as staff meetings and clinical pathology conferences which constitute excellent ways for on-the-job continuing education.

The continuing education programs in medicine included in the Regional Medical Programs are directed to those physicians who do not have hospital affiliations or, therefore, the disciplinary pressure of a hospital affiliation regarding the continuing education activities.

Hospitals have had little effect on the continuing education of the dentist except for that small percentage of dentists who participate actively in the relatively few effective hospital dental services. The ADA has long and actively promoted the cause of continuing education. Dental societies have conducted well-organized continuing education programs. Dental schools have made contributions to continuing education with postgraduate courses and seminars. Continuing education in dentistry has not been effective on a mass basis in any of these areas.

There has been an interest in continuing dental education with the promulgation of the regulations by the New York State Department of Health which require that a dentist have 25 hours of continuing education per year to maintain eligibility to treat patients under the state Medicaid program. There is also evidence that the State Department of Education is studying the problem of requiring evidence of continuing education for renewal of dental license.

Regional Medical Programs provide an excellent opportunity for the creative and most productive development of continuing education. To accomplish this, continuing education programs must:

- Establish standards that will give maximum consideration to the needs of practicing dentists, the improvement of care to the public, and a greater degree of integration of dental care with the total health program and with other health professionals.
- Provide the dental profession with a greater understanding of the medical problems of the patient, particularly in the areas of heart disease, cancer, stroke, and related diseases.
- Improve the dentist's understanding of the total, organized health care program of the nation, the state, and the community in order that he may understand the environment in which his services, knowledge, and skills are to be distributed.
- Increase the dentist's understanding of new systems and arrangements of practice as the evolution of new delivery systems for health care proceeds, particularly hospital dental practice, group practice, or combinations of both.
- Improve the general level of dental care by keeping all dentists abreast of present concepts of dental practice.
- Attract the dentist on the merits of the additional knowledge and skill gained from the continuing education program and be designed to meet his needs as determined by his practice in locations that will be convenient.

Design and development of new concepts for the delivery of dental care

One of the major objectives of Regional Medical Programs is the experimentation in and development of more effective delivery systems of health care. For dentistry, this provides an opportunity to establish demonstration projects that will relate the best factors in government programs, such as the OEO and Children's Bureau children and youth projects, with those of the hospital administrative capability and the professional capability of the dentist practicing in the fullest concept of intellectual and professional freedom.

These demonstration projects should keep the professional factors in dental care within the control of the professional dental group. They will also assure the highest quality of professional care rendered in the public practice administered by the hospital and the private-group practice conducted in a dental facility established and administered by the hospital. The hospitals in which the initial projects can best be established should be those hospitals that have a dental-teaching affiliation, some form of government supported comprehensive care program, a progressive care fa-

cility where many patients with heart disease, cancer, stroke, or related diseases are stabilized and rehabilitated and where the imagination of a dynamic health professional core exists in the medical and dental staff, the hospital board, and the hospital administration.

The potential of dental education, continuing dental education, dental research, and dental care can be accommodated in such an environment with full protection of the professional prerogatives of the dentists involved. There is no question that such experimentation must develop pressures that require the utmost of good professional administration, patience, and willingness to produce equitable and balanced results. Such experimentation is the only effective way in which the health professions and the allied agencies can maintain their intellectual and professional freedom in a dominant position while they make the maximum use of government support in our ever more organized society.

Training and treatment centers for maxillofacial rehabilitation

The increasing number of patients who have received head and neck surgery or radiation therapy for the control of cancer of the head and neck and the patient with a stroke who often loses all his teeth during his stroke episode and stabilization require a specialized system of oral rehabilitation, including speech rehabilitation, if after the initial treatment their lives are to be productive and adjusted.

There are many persons who are separately developing technics and concepts for the management of these problems in oral rehabilitation. There is a great need for the development of regional centers for the care of these patients as well as the training of dentists for these more specialized problem-solving responsibilities. These centers should also be expected to conduct extensive clinical research in the area of maxillofacial rehabilitation. Another benefit of such programs would be the inclusion of such closely allied problems as cleft lip and cleft palate, oral and speech rehabilitation, and unusual problems such as muscle spasm, temporomandibular joint dysfunction, and their relation to functional dental occlusion. Certainly, projects to organize on a regional basis the care, research, and training in these areas are proper functions of Regional Medical Programs.

Regional conferences to stimulate regional community action in the development of project ideas

Consideration should be given to the use of conferences to involve the health professionals, the hospitals, the health agencies, and other pertinent persons in organizing appropriate health care projects for patients with heart disease, cancer, stroke, or related diseases.

In dentistry, it would be most desirable to hold such a conference for adjacent communities that have common characteristics in the provision of dental care for patients with heart disease, cancer, stroke, or related diseases rather than the development of small, duplicate, expensive programs. If such conferences demonstrate or develop the realization that a project established for the region which will assure adequate dental care for patients with heart disease, cancer, or stroke; that a regional project will benefit the dentists of the total region in providing continuing education; that the project can improve and expand hospital dental services to the benefit of everyone, then dentistry and the public can gain from such a conference. If the idea is not activated at the present time, it will progress no further in 20 years.

Summary

There is an excellent potential for dentistry in the Regional Medical Programs. The only limitations for dentistry lie within the creative imagination and dynamics of the dental profession. Regional Medical Programs provide opportunities for bringing the whole of dentistry into the future mainstream of health care in a highly organized society with highly organized health services. They provide an opportunity for dentistry to be involved from the beginning in assuring the best professional standards supported by intellectual and professional freedom as the essential foundation for an organized society's organized health services.

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